Ministerie van Buitenlandse Zaken



Sexual and Reproductive Health and Rights

Organisation	Date	Reporting Period
Social Development Department Ministry of Foreign Affairs, the Netherlands	August 13th 2015	2014

Activity		2014	Implemented by		Rio marker		Gender marker
Number	Name	Actual expenditure	Name Organisation	channel	mitigation/adaptation	significant/principal	significant/principal
				...	...	...	...
26185	DSO - GFATM 2014 - 2016	74.181.000	Global Fund to Fight AIDS, Tuberculosis and Malaria	Multilateral organization	Not applicable	Not applicable	Principal
21814	GAVI III (2011-2015)	32.000.000	The GAVI Fund	Multilateral organization	Not applicable	Not applicable	Not applicable
24485	DSO Global Programme ERHCS	19.500.000	UNFPA - United Nations Population Fund	Multilateral organization	Not applicable	Not applicable	Not applicable
21558	DSO Contributie IFFIm	13.650.000	IBRD- International Bank for Reconstruction and Dev'm.	NGO	Not applicable	Not applicable	Not applicable

Activity		2014	Implemented by		Rio marker		Gender marker
Number	Name	Actual expenditure	Name Organisation	channel	mitigation/adaptation	significant/principal	significant/principal
24914	DSO SRGR A03 Link UP	9.389.040	International HIV/AIDS Alliance	NGO	Not applicable	Not applicable	Principal
24912	DSO SRGR A09 CORDAID	9.115.000	Cordaid	NGO	Not applicable	Not applicable	Principal
24485	DSO Global Programme ERHCS	8.000.000	UNFPA - United Nations Population Fund	Multilateral organization	Not applicable	Not applicable	Principal
23176	DSO - KPF Aids Fonds 2011-2015	7.800.000	Stichting Aids Fonds	NGO	Not applicable	Not applicable	Not applicable
24913	DSO SRGR A11 RutgersWPF	5.261.000	WPF (World Population Foundation)	NGO	Not applicable	Not applicable	Principal
26474	DSO - UNICEF 2014-2015	5.000.000	UNICEF	Multilateral organization	Not applicable	Not applicable	Principal
26999	UNICEF Child marriage	5.000.000	UNICEF	Multilateral organization	Not applicable	Not applicable	Not applicable
27002	UNICEF Social protection	5.000.000	UNICEF	NGO	Not applicable	Not applicable	Principal
24725	DSO Opstap Fonds	4.303.240	Soa Aids Nederland	NGO	Not applicable	Not applicable	Principal
18969	DSO GHPSR NWO-WOTRO	3.325.000	NWO - Ned.Org. voor Wetenschappelijk Onderzk	Research institute and comp	Not applicable	Not applicable	Not applicable
23383	DSO PDPneglected diseases DNDi	3.300.000	Drugs for Neglected Diseases initiative - DNDi	PPP or network	Not applicable	Not applicable	Not applicable
22191	DSO PDP subsidie IAVI 2011/14	3.135.000	IAVI (International AIDS Vaccine Initiative)	PPP or network	Not applicable	Not applicable	Principal
24935	DSO SRGR B21 Rutgers WPF	3.088.000	WPF (World Population Foundation)	NGO	Not applicable	Not applicable	Principal
23384	DSO PDP TB Vaccins (AERAS)	2.757.856	AERAS Global TB Vaccine Foundation	PPP or network	Not applicable	Not applicable	Not applicable
23387	DSO PDP diagnostics (FIND)	2.404.280	FIND - Foundation for Innovative New Diagnostics	NGO	Not applicable	Not applicable	Not applicable
22192	DSO PDP subsidie IPM 2011-2014	2.215.714	International Partnership Microbicides - IPM	PPP or network	Not applicable	Not applicable	Not applicable
24934	DSO SRGR B26 Save the Children	2.195.000	Save the Children	NGO	Not applicable	Not applicable	Principal
24939	DSO SRGR KIT B11	2.177.000	Koninklijk Instituut voor de Tropen	Research institute and comp	Not applicable	Not applicable	Principal
24937	DSO SRGR B15 AMREF FD	2.055.000	AMREF Nederland	NGO	Not applicable	Not applicable	Principal
22185	Keuzes en Kansen IPPF	2.000.000	IPPF- International Planned Parenthood Foundation	NGO	Not applicable	Not applicable	Principal
22187	Keuzes en Kansen IPAS	2.000.000	IPAS	NGO	Not applicable	Not applicable	Principal

More activities

Result Area 1	Young people are better informed and are thus able to make healthier choices regarding their sexuality					
Result Question 1a: To what extent are young people better informed? What evidence is there that they are making healthier choices regarding their sexuality?	Globally many successes have been booked in efforts to combat AIDS (see also result area 2). However, among young people (aged 15-24), despite special efforts targeting this group, many new HIV infections (220,000 in 2013) arise and it is estimated to be the only age group in which deaths due to AIDS are not decreasing (UNAIDS MDG6 report, 2015, p.375). UNAIDS states that AIDS is even the 'leading cause of death among adolescents in Africa (aged 10-19 years) and the second cause of death among adolescents globally' (UNAIDS, 2015, p.375). Comprehensive knowledge of HIV transmission remains low among young people in 2014. Globally, there has been little change in the percentage of young people having accurate and comprehensive knowledge about HIV transmission (UNAIDS MDG6 report, p.100). Since 2000, youth in Sub-Saharan Africa -the region most affected by the HIV epidemic- overall saw a 9% increase for both sexes of their comprehensive knowledge of HIV, but a decrease in knowledge for men since last year (UN MDG report 2014, p.35). In 2014, 30% of women and 37% of men had comprehensive knowledge, according to the same report. Reductions in incidence of HIV transmission that did occur can be attributed to delayed sexual debuts, fewer sexual partners and condom use (MDG 6 report 2015, p.33/101). In Sub-Saharan Africa the condom use among young men and young women who had higher-risk sex slightly increased (F: 40% M: 59%), but is far					
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Percentage using condoms at last high-risk sex, by gender and for age 15-24 specifically if possible (MDG indicator 6.2), in Sub-Saharan Africa	(2002-2008) F:35% M: 48%	reach 95%	F: 30% M: 49%	(2006-2012) F: 37% M: 57%	F: 40% M: 59%	UN MDG report 2014, p.35 UN MDG report 2010, p.12 UN MDG report 2015, p.45
Percentage of young people (15-24) with comprehensive correct knowledge of HIV/aids (MDG indicator 6.3) in Sub-Saharan Africa	2002 F: 25% M: 31%	reach 95%	F: 28% M: 36%	(2006-2012) F: 28% M: 39%	(2007-2014) F: 30% M:37%	UN MDG report 2014, p.35 UN MDG report 2015, p. 45

Result Question 1b (1): With which results has your programme contributed to comprehensive sexuality education for young people in and outside of school? **Result Question 1.b (2):** With which results has your programme contributed to opportunities for young people to have their voice heard and stand up for their rights?	The Netherlands supports NGOs that implement comprehensive sexuality education (CSE) programmes and provide youth-friendly services through programmes and alliances such as the 'Together for Change Alliance', the 'SRHR Alliance', the IHAA Link-Up programme, Connecting the voices of youth programma (HIVOS and Global Dialogues), the Faith to Action Initiative, IPAS, IPPF, Women Deliver and Save the Children. Furthermore, with help of our contribution, UN organisations such as UNFPA, UNICEF, UNAIDS and WHO established technical guidelines for sexuality education, and advocate for the right of information and services for young people and facilitate its implementation at country level. Through these different activities over 28 million young people have been able to use SRH services, over 16.000 schools were supported to adopt CSE in their curricula and over 5.5 million youth in & out of school were reached with information on sexuality, HIV, STIs, pregnancy, contraceptives through our funded activities. Naturally, each individual activity/programme has its unique characteristics, targets, results and means of implementation. Also, since December 2014 the Dutch Ministry has appointed a Youth Ambassador for SRHR. Her work is to be the voice of the youth in national and international events on SRHR, increase visibility of the work on SRHR and strengthen the understanding between young SRHR experts and policy makers.					
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Number (or %) of youth-friendly (health) centres	-	SRHR Alliance: 1.250.000 (2015)	SRHR Alliance: 443.403	SRHR Alliance: 1.053.287	SRHR Alliance: 994.063, UFBR:70	SRHR Alliance (2014, p. 78) UFBR p. 19
Number of youth (10-24) using sexual and reproductive health services by organisation supported	-	Ask: 1250000	-	IPPF: 11.066.037 ASK: 1.053.287	Sum IPPF, ASK, FTA & UFBR = 28.466.679	IPPF Annual Report Choices & Opportunities ASK, ASK 2014 p.19, UFBR p.19, F2A.
Number of schools that adopt comprehensive sexuality education	-	NA	-	ASK, ICCO, T4C, SRHR Alliance & KIR = 2294	ASK, ICCO, T4C, SRHR All., KiR & UFBR = 17.418	2013: Annual Reports IPPF Choices & Opportunities, ICCO Alliance, 2014: ASK p.19, UFBR p.19, ICCO Alliance p.142, T4C p.26, SRHR Alliance p.76, KiR p.7
Number of youth (10-24) in school & out of school reached with information on sexuality, HIV, STIs, pregnancy, contraceptives	-	Ask: 150000	FTA: 341.000	2.085.800	5.756.907	2013/2014 Annual Reports Link-Up, ASK, KiR, FtA, SRHR Alliance, IPPF, ICCO Alliance, T4C, CVY.

More indicators

Assessment of results achieved by NL across the entire Result area 1	Young people are better informed and are thus able to make healthier choices regarding their sexuality
B. Results achieved as planned Reasons for results achieved:	Youth-friendly services and information provided by our partner organisations focus on sexual and reproductive health services, comprehensive sexuality education, safe abortions, HIV and abortion-related services, contraceptive services and condoms provided. The organisations have been able to obtain results as they employ a variety of strategies. These include peer education, i.e. involvement of youth volunteers in project design, implementation, monitoring and evaluation. Also, these include non-traditional, interactive pedagogy skills in training, training in child-friendly spaces. The partners also work to ensure that clinics are youth-friendly and they train and mobilize parents and teachers and provide CSE in and out of schools. The signing of the East and Southern Africa (ESA) agreement on the introduction of CSE in school curricula by ministers of health and education of 20 ESA countries in December 2013, under the auspices of Unesco is still an important reason for the results achieved. Also, different SRHR/CSE programs have been developed for specific regions within countries (instead of one CSE/SRHR program per country) and for specific target groups. Increasingly, popular social media and mass media is being used (Connecting the voices of youth).
Implications for planning:	In recent years the awareness of the importance of active participation of youth increased dramatically. Many legal and social barriers remain but more young people do gain access to information and services and in some countries young people's voices get heard more. However, adolescent fertility rates, early marriages and new HIV-infections are still unacceptably high. Rates of unwanted teenage pregnancies are alarming in some countries and engagement of men and boys in family planning lags far behind. The challenge is now to increase scale while being sensitive to the local contexts, in order to change attitudes and particularly behaviour among young people themselves and their service providers. Embassies are increasingly supporting efforts to end child marriage, through engaging with national and international (e.g. Girls not Brides) alliances, dialogue with government or projects on CSE. Furthermore, alliances should find ways to deal with challenges such as external and environmental issues, the lack of classrooms and shortages of IEC materials and the persisting taboos in many areas of sexuality. The ministry will continue to invest in enhancing access to accurate and age-appropriate information about sexuality for all young people and adolescents, whether in or out of school. Access to youth-friendly services for sexual and reproductive health, e.g. modern contraception and STD-testing, is an essential component of this work. A focus will be furthermore on generating better understanding of how knowledge gets translated into attitude and behavior. There will be a continuation of support for meaningful youth participation in advocacy, implementation and accountability for SRHR and HIV policies and programmes, in The Hague through the Youth Ambassador for SRHR and at the embassies. The Ministry also will continue to support investments to help end child, early and forced marriage (see result area 4 also).

Result Area 2	A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health					
Result Question 2a: To what extent do more people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health?	Despite the alarming data on young people with HIV infections, especially in some regions, the total of new HIV/AIDS infections in Sub-Saharan Africa declined by 41% between 2000 and 2014 (UNAIDS MDG6 report, 2015, p.33). Access to antiretroviral therapy (ART) has averted 7.8 million deaths and 30 million new infections between 2000 and 2014 (UNAIDS 2015, p.33). Even taking into account the broadening criteria for receiving ART, the doubling of the amount of people receiving ART between 2010 and 2015 -from 7.5 million to 15 million- is a big success. Of all people with HIV globally 38% is receiving ART. Disparities remain between men and women and regions. Less than 25% of children receive ART. Last year we reported that the percentage of HIV-positive pregnant women who receive ART to prevent HIV transmission to their babies increased from 48% in 2010 to 64% in 2012, and in 2014 this number went up to approximately 73% (UNAIDS MDG6 report 2015, p.33). In twenty-one high priority countries in Sub-Saharan Africa about 77% of women are reached with services that help prevent mother-to-child transmission of HIV (UNAIDS MDG6 report 2015, p.57). Family planning is still perceived as one of the most effective and cost-effective ways to save women's, girls and children's lives as well as to improve their health. The cost savings being the greatest among adolescent mothers at a savings of $17.22 for every dollar spent on contraception for women aged 14-19 (UNFPA					
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Contraceptive Prevalence Rate - modern methods- all married women 15-49 in developing regions	1990: 52% (all methods)	NA	63% (all methods) Sub-Saharan Africa: 20%	44% modern methods, 50,5% all methods.	44,5% modern methods, 51% all methods.	PRB 2013: World Population Data sheet, p.13, MDG report 2014, p.32, UNFPA State of the World Population 2013, p.105, UNFPA SWOP 2014, p.109.
Contraceptive Prevalence Rate - modern methods- all girls 15-19	-	NA	-	21%	-	UNFPA State of World Population 2013, p.37
Unmet need for family planning of married women 15-49 years old, in developing regions	17% Sub-Saharan Africa: 28%	NA	12% Sub-Saharan Africa: 25,1%	-	24% in Sub-Saharan Africa	MDG report 2014, p.32 MDG report 2015, p.41
Unmet need for family planning of girls 15-19 years old	-	NA	-	15%	-	UNFPA State of World Pop. Report 2013, p.37

Result Question 2b (1): With which results has your programme contributed to a greater choice in and sufficient availability of contraceptives/medicines? **Result Question 2b (2):** With which results has your programme contributed to addressing sociocultural barriers preventing women from using contraceptives?	The Netherlands supported global programmes, UN organisations, NGOs, government services in partner countries and product development partnerships (PDPs) in 2014 that have the aim to improve the access of SRH commodities for all people. As in 2013, the programmes tackle the supply side, but also pay attention to the sociocultural barriers that prevent women from using contraceptives or HIV+ people to access ARVs. In 2014, the Netherlands worked on this objective through the funding of the product developers such as Product Development Partnerships; organisations that help to distribute these products such as the Global Fund to fight Aids, TB and Malaria, GAVI the Global Vaccine Alliance, the UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) and IPAS. But also programmes and organisations such as the IHAA Link-Up programme, Population Service International and the Universal Access to Female Condoms programme were supported who work with and in networks to improve access to these services and commodities. Also, support was provided to the Access to Medicine Foundation to stimulate sustainable access to medicines through a Sustainability Index. In 2014, the investments in this area led to a large number of results along the value chain from product development to delivery, and access. For instance, the					
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Number and type of new, user-friendly products / medicines on the market for improved sexual and reproductive health	1 female condom (FC)	NA	2 FC	2 FC	2 FC (cumulative)	UAFC Annual Report 2013
Number of couples protected by various contraceptives (Couple Year Protection = CYP)	-	NA	IPPF: 3.000.000 GP: 29,244,814	IPPF: 4.400.000 GP: 35.079.117 UAFC: 32.418	IPPF: 6.142.313 GP: 28.400.000 PSI/COF: 241.424	Annual Reports 2013 IPPF and PSI COF, UAFC, GPRHCS. Annual reports IPPF, PSI & UAFC.
Number of male and female condoms distributed	IPPF: 11.000.000	NA	IPPF: 17.000.000	IPPF: 16.100.000 male: 236.956.324 female: 19.447.26	334.264.030, male: 438.420.000 female:13.364.500	Unspecified is IPPF, ASK, PSI , GFATM cumulative male: GPRHCS, female: GPRHCS + UAFC cumulative. Cumulative all = 786.048.530
Number of children immunised with vaccines	2010: 296 million	(plus 243 million) 539 million	393 million	447 million	503 million	GAVI progress report, 2013, 2014

More indicators

Assessment of results achieved by NL across the entire Result area 2	A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health
B. Results achieved as planned Reasons for results achieved:	It is our aim that a growing number of people get access to and make use of modern contraceptives, (female) condoms, antiretroviral therapy (to contain HIV), and other essential commodities for sexual and reproductive health (e.g. STD testing, safe delivery equipment and medication). This means that we invest in the development of new contraceptives medicines, vaccines and in making these products widely available, affordable and accessible. Whether people actually use these commodities however also depends on the quality of the services and on so-called demand-side issues, such as stigma or attitudes in society towards sexuality and contraception. Through a systemic and country-driven approach towards innovative product development, product delivery, improving access and affordability the ministry's resources have contributed to a wide range of results. It led to strong collaboration between donors, researchers and the private sector and increased the availability of vaccines, drugs, HIV-testing and SRHR commodities such as contraceptives and products for medical abortion. However, progress is not sufficient everywhere. We notice that in many countries unmet need for contraception hardly goes down: 225 million women want to postpone a pregnancy or stop child bearing but are not using modern contraception. Therefore, the Ministry engaged with religious and other community leaders to take away some of the social barriers. Particularly adolescents continue to have limited access to appropriate contraceptives, HIV/STI-prevention and treatment and safe abortion options.
Implications for planning:	People need diverse commodities (contraceptives, medicines and medical devices) that enable them to have safe sex, safe pregnancy and safe delivery, and - if women so desire- safe abortions. However, many people lack the knowledge about and access to essential products and commodities leading to a host of undesirable consequences. Furthermore, the chains - from research, development, and production, distribution of commodities and products to people using these commodities and products - are long and complex. Gaps, barriers or interruptions anywhere along those chains currently severely reduce impact. These gaps and barriers are varied along the value chain and are related to advocacy, finance, supply chain management, integration of services, scaling up and contextual readiness but also cultural belief systems, fear for side effects of the use of certain commodities and underestimation of risks. Future priorities will be to continue to address a number of the weak links in the value chain for SRHR including HIV where NL has an added value, specifically for marginalized populations, adolescents and youth and women, by using our funds and convening power. The country thematic experts will continue to provide valuable insights in how our programs work at country level -with specific attention to reducing inequalities in access and use; but also specific attention to end-users' needs, perceptions and feedback. Most of this work requires a stronger involvement of the private sector. In the Netherlands we will continue to stimulate product innovations through the Top Sector Life Sciences for Health and Development window and keep an eye out for Dutch initiatives that can contribute to commodity availability and use. Through our strategic partnerships under development, and collaboration with iNGOs, the RHSC, HRP and others, we will enhance knowledge about use and demand issues, and learn about gaps in the spectrum of commodities for SRHR, incl. HIV.

Result Area 3	Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using
Result Question 3a: To what extent has the use of sexual and reproductive healthcare services in the public and private sector improved?	MDG 5's goal was to improve maternal health. Between 1990 and 2013 the maternal mortality rate (MMR) dropped by 45% from 280 to 210 deaths per 100,000 live births. No region as a whole has come close to reaching the MDG 5.A target to reduce the maternal mortality ratio (MMR) by three quarters. Eastern Asia booked the most progress, reducing their MMR between 1990 and 2013 with 65% (UN MDG report, 2015, p.38, WHO, UNICEF, UNFPA, The World Bank & UNDP, 2014, p.21). In Sub-Saharan Africa the MMR went down with 49%. Sub-Saharan Africa accounted for 62% or 179,000 of all the 289,000 women dying of pregnancy or child-birth related consequences worldwide, having the highest risk of maternal mortality at 1 in 38 (WHO, UNICEF, UNFPA, The World Bank & UNDP, 2014, p.21). A contributor to reduce the maternal mortality ratio is the provision of good quality antenatal care and attendance of birth by skilled health personnel. The proportion of women who received antenatal care by skilled health-care personnel at least once during pregnancy was 83% for the period 2007-2014 (WHO World Health Statistics, p.18). However the World Health Organization (WHO) recommends a minimum of four antenatal care visits. Globally only 64% of women receives this minimum of four antenatal care visits, for developing regions this is 52% (WHO World Health Statistics 2015, p.18, UN MDG report 2015, p. 41). This

	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Antenatal care coverage of at least one visit (MDG indicator 5.5) - developing countries	65%	80%	81%	82%	(2007-2014) 77% WHO African region,83%globally	MDG Report 2014, p.30 WHO World Health Statistics 2015, p. 12
Antenatal care coverage of at least four visits (MDG indicator 5.5) - developing countries	37%	80%	51%	52%	52%	MDG Report 2014, p.30 MDG report 2015, p.41.
Proportion of births attended by skilled health personnel (MDG indicator 5.2) - developing regions	56%	90%	66%	68%	70%	MDG 2014 Report
Proportion of births attended by skilled health personnel of 20% poorest	no baseline	90%	-	(2007-2012: 31%	-	UN DATA (UN.DATA.ORG)

Result Question 3b (1): With which results has your programme contributed to improved cooperation between public and private healthcare services? **Result Question 3.b (2):** With which results has sexual and reproductive health care including emergency obstetric care become more affordable and accessible?	Many of the activities in this result area take place through the bilateral programmes, but centrally funded partners also implement programmes at country level that complement bilateral support. There is close collaboration between not-for-profit providers (MSI, IPPF, PSI) and Ministries of Health with innovative models for social franchising of providers and clinics, the use of mobile technology for referral by community health workers to commercial outlets and public services and performance based financing. Smart application of diversification in financing systems, whereby those who need free services can get them and those who can afford to pay do so, is one way of making services available in a (more) sustainable manner. All of this is leading to increased coverage of contraceptive services, ante-natal and post-natal care, more use of safe abortion services, expansion of VCT for HIV/STIs and improved quality of care. In 2014, over 13.000 midwives were trained, health staff and community health workers were trained in ante-and post natal care, safe deliveries and basic health care (over 15.000) through the funded programmes and almost 240.000 mothers received ante and post natal care through these funded programmes. The Business for social responsibility HER (health enabled results) project aims at improving access to health services (incl. SRHR) for female workers within the workplace and surrounding community, raising awareness on SRHR issues and training farm-based nurses. In 2014 90 more factories joined the programme (in

	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Number of midwives/ skilled birth attendants trained	NA	NA	-	increase of 35% availability of midwives	13.084	UNFPA, 2014: UFBR
Number of health staff and community health workers trained in ante- and post natal care, safe deliveries and basic health care	NA	NA	HIF: 508-	Link up: 220* AMREF: 2168 HIF: 1276	AMREF: 1130, SRHR: 13084, CD: 1800. Total:16.014	Link - up; *no. of private service providers trained AMREF Health Insurance Fund rep 13, AMREF: Annual rep 14, SRHR Alliance p.77, CDA p.58.
Number of mothers receiving ante & post natal care	11.389	43.500	11.856	43.900	CD: 66.000 ASK: 169.354 Total: 235.354	CD Alliance, Child Development Alliance (2014, p.59), ASK p.19.

More indicators

Assessment of results achieved by NL across the entire Result area 3	Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using
C. Results achieved poorer than planned Reasons for results achieved:	Universal access to reproductive health care is far off track and only slowly improving. Especially the poorest population groups are not yet reached despite of the numerous efforts that countries have put in place. A lack of qualified and motivated human resources remains a bottleneck. However, several initiatives have been undertaken to address this bottleneck, such as for instance the mother mentor initiative to ensure women attending ante and postnatal clinics (Child Development Alliance, 2014). A well-functioning health system is needed to deliver sexual and reproductive health care to all, including young people and disadvantaged groups. Ideally those services are delivered in an integrated manner: all the services that someone needs in one place (so antenatal care and STI (incl. HIV) testing combined; post abortion care combined with counselling on contraceptives). Public and private (for profit and not-for-profit) players all have their roles to play, in quality control, service delivery, staffing, financing. In order to bring services closer to the clients the task shifting - more responsibilities to lower level cadre health workers- is gradually being developed and applied. New means of communication can be extremely helpful in connecting clients/patients to services, therefore the Ministry is supporting innovative approaches in this area, and works to include private sector partners in its activities.
Implications for planning:	Community based approaches, innovative and holistic approaches and a mechanism that reaches out to the poorest population groups will be essential to ever reach universal coverage. Besides, efforts to harmonize public and private sector are scarce and only few good examples exist. More resources are needed to encourage complementary cooperation between both sectors in order to achieve universal coverage of reproductive health services. Active and financial participation in the recently launched Global Financing Facility operated by the Worldbank, will for instance be carefully considered. Furthermore, the Ministry will contribute to health systems strengthening by improving the interplay between public and private stakeholders and local communities, through dialogue on clarity of respective roles (regulation, standard setting, quality control, service delivery, health financing, human resources, accountability) and supporting concrete optimisation of this system. Also, it will continue to work to reduce the critical gaps in service delivery (equity, underserved groups, abortion) and staffing (including midwifery) and promote integrated service delivery and task shifting. We will continue to make use of the NICHE programme to support human resources development, in particular training of midwives. It will aim to stimulate improvements and innovation in health financing, through a combination of improved public finance management and innovative financing models; performance based financing and better health insurance schemes. It will strengthen collaboration with the private sector to expand the provision of SRHR, including HIV services at the workplace. Also, a focus will be on fragile states and during humanitarian crises where service delivery is weak. Lastly, it will foster accountability mechanisms for end-users and patients. Mobile and other technology offers many opportunities for bottom-up accountability and subsequent advocacy. We intend to invest more time into tying the insights we have gained from our various programs (country-level, NGOs, multilateral) to the international debate.

Result Area 4	Greater respect for the sexual and reproductive rights of people to whom these rights are denied
Result Question 4a: To what extent have the conditions for women, young people, sexual minorities, sex workers and intravenous drug users improved with regards to their sexual and reproductive rights?	In several countries themes as sexuality, maternal mortality and HIV/AIDS are difficult to address. Recognition of sexual and reproductive health and rights and gender equality have not yet been achieved globally. In several countries, sexual and reproductive rights of marginalized groups, also known as key populations (e.g. sex workers, injecting drug users and sexual minorities) are violated. At the same time, these groups are disproportionately affected by the AIDS epidemic (UNAIDS MDG6 2015 p. 94). Female sex workers have a 13.5 times higher chance of getting infected by HIV than other women their age and one in four transgender female sex workers have HIV (WHO 2015, p.6). People who inject drugs have a 28 times higher HIV prevalence than the general population (UNAIDS MDG6 report 2015, p.350. Of the estimated 16 million people that are injecting drugs worldwide around three million of them are living with HIV (WHO, 2015, retrieved from: http://www.who.int/hiv/topics/idu/en/). Men who have sex with men (MSM) are 19 times more likely to get infected with HIV than the general population (UNAIDS MDG 6 report 2015, p.350). Transgender women are 49 times more likely to be living with HIV than other adults of reproductive age (UNAIDS MDG 6 report 2015, p.350; WHO 2015, p.6). The number of new infections among key populations remains relatively steady (UNAIDS MDG6 report, 2015).

	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Percentage of women married before age 18 in 20-24 year age group	(2010) 13,5% (2000-2011) 34%	NA	-	(2005-2012) 65%	(2005-2013) 40% in SSA, 45% in LDC, 27% globally	UNFPA Marrying too Young (2012), UNICEF global databases based on DHS, MICS and other national household surveys - last update Oct. 2014.
Percentage of female genital mutilation in 15-49 year age group - Sub-Saharan Africa	NA	NA	-	(2002-2011) 40%	(2005-2013) 39%	UN DATA (un.data.org), UNICEF global databases based on DHS, MICS and other national household surveys - last update Oct. 2014.

Result Question 4b (1): With which results has your programme contributed to the identification of or changes in legal and policy barriers for the sexual and reproductive health of women, young (unmarried) people, sexual minorities, intravenous drug users and sex workers? **Result Question 4b (2):** With which results has your programme contributed to improving the access of these specific groups to sexual and reproductive health services and commodities?	In many countries sexual and reproductive rights and the right to sexual and reproductive health (care services) are not fully upheld. Next to girls, youth, women in general, a number of groups are most often denied those rights and are stigmatised and criminalised. The denial of their rights has a serious negative impact on their lives and health. This is an area where the Netherlands can have significant added value since it is one of the few donors who are prepared to address the health and human rights issues of vulnerable groups such as (poor) women and adolescents/youth and populations that are key for HIV prevention (sex workers, men having sex with men and intravenous drug users). Through various programmes and NGOs (such as IHAA Link Up, Women Deliver, IPAS, Bridging the Gaps, ICCO alliance), the Ministry works with these key groups. Also, local initiatives and international efforts are being supported towards making abortion safe, rare and legal. This is done through a multi-pronged approach: providing concrete support under result areas 1, 2 and 3, working on the international human rights framework (e.g. ICPD and Post-2015) and applying that framework in advocacy for national legislation, policies and accountability through result area 4. In terms of results, we see in a number of countries a worsening of the situation, e.g. increased homophobia, sexual and gender based violence and opposition against women's (reproductive) rights. At the same time, many sensitive issues like child marriage, FGM and comprehensive sexuality education are nowadays subject to

	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Source
Perceived change in public statements made by leaders / personalities advocating for sexual and reproductive rights: of women, young (unmarried) people, sexual minorities, sex workers and intravenous	2013: cross-regional statement in UN setting	NA	-	Statements in HRC and OWG4	Statements in OWG8, OWG13, 50,58, co-sponsors	HRC statement, OWG8 and OWG13 Joint SRHR Statements.
Number of key populations having received sexual and reproductive health services and information	NA	NA	-	544.090	364.564	Bridging the Gaps, Annual Report 2013 Stepping Up, Stepping Out, Annual Report 2013 CAHR Annual Report 2013

More indicators

Assessment of results achieved by NL across the entire Result area 4	Greater respect for the sexual and reproductive rights of people to whom these rights are denied
C. Results achieved poorer than planned Reasons for results achieved:	As we have described last year, it is essential that changes in this result area take place both at the international level (agreed language at the UN), at the national level (laws) and on a practical level with the relevant target groups (girls, LGBT groups, sex workers, people who inject drugs) and service providers (schools, clinics, police). As legal reforms happen slowly, we note that results in this area are more difficult to achieve. However, at the more practical level, many NGOs have been able to reach out to key populations with often remarkable results. In addition, we also see increased attention for SRHR in the human rights mechanisms, such as the Universal Periodic Review, Special Rapporteurs and Treaty Bodies. Recognition of SRHR as human rights through this system is essential for better implementation of SRHR objectives as well as accountability of stakeholders including governments.
Implications for planning:	In every part of the world, including the Netherlands, some people are denied their sexual and reproductive rights. Protecting, respecting and fulfilling sexual and reproductive rights is therefore a truly universal objective but at the same time the approach may need to be context specific. Reforms are however happening slowly and results will take some time. Legal reforms that are in line with internationally agreed human rights are important steps in fulfilling the sexual and reproductive rights of people. Apart from the legal environment there is the policy reform and its implementation that will make a real difference for the people. After all, respecting people's rights requires a behavioral change, from the general population in the communities and from the professionals implementing this policy and laws such as health workers, the police, the legal forces. Power relations, religious barriers, different norms and values in the communities are not easily changing and require time. The Netherlands will need to remain consistent in its message, coming up for the rights of youth, sexual minorities, and marginalised people, while building alliances with like-minded southern and northern partners. In the next year therefore even more attention be given to lobby and advocacy for inclusive health policies and programs on national level. The strategic partnerships that are being developed under 'Dialogue and Dissent' and those that will be selected in the course of 2015 will be important for achieving results in this area. We will continue our work with key populations, by strengthening communities and networks that can advocate effectively for de-stigmatization, de-criminalization, legal changes and better service delivery. We will continue building and using the international human rights framework related to sexual and reproductive health and rights, and HIV and AIDS by working with like-minded and reaching out to less like-minded partners (countries, regional bodies/organizations including EU, as well as through our seat in the Human Rights Council) with the aim to accelerate progress on SRHR at country level. We will work to strengthen accountability mechanisms vis-a-vis governments, local governments and other service providers, like (international) NGOs and faith-based organisations and support the movement to end child, early and forced marriages and provide political support for the eradication of FGM, and for safe abortions.

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Result Area 1 (remaining indicators)	Young people are better informed and are thus able to make healthier choices regarding their sexuality					
Result Question 1a: To what extent are young people better informed? What evidence is there that they are making healthier choices regarding their sexuality?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**

Result Question 1b (1): With which results has your programme contributed to comprehensive sexuality education for young people in and outside of school **Result Question 1b (2):** With which results has your programme contributed to opportunities for young people to have their voice heard and stand up for their rights?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Number of schools with HIV/Aids education	191	75	208	702	-	ICCO Alliance
Pupils and teachers with changed attitudes as well as improved knowledge and skills for protection against HIV/STI transmission and unwanted pregnancies	1098	60%	1266	8016 (52%)	2.370 (IPPF)*	ICCO Alliance, *IPPF Annual Report 2014: young people were trained as advocates for CSE.
Children and young people demonstrate positive behavioural change on SRHR	1263	3641	-	5576	1.279.195 (UFBR)	Together 4 Care, UFBR p.19

Back to result area 1

Result Area 2 (remaining indicators)	A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health					
Result Question 2a: To what extent do more people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Proportion and number of the access to antiretroviral therapy of people living with HIV (MDG indicator 6.5), in developing regions	2003: 800.000	15 million people (80% of HIV patients) (2015)	9,7 million	(globally): nearly 13 million	(globally): 13.6 million	UN MDG Report 2014, p.36, UNAIDS Global report 2013 + Gap Report, july 2014, 2014: UN MDG Report 2015, p.6/44.

Result Question 2b (1): With which results has your programme contributed to a greater choice in and sufficient availability of contraceptives/medicines? **Result Question 2b (2):** With which results has your programme contributed to addressing sociocultural barriers preventing women from using contraceptives?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Annual outreach of innovative/alternative models and pilots for service delivery in SRH are implemented: 5,000 people given access to aids prevention, legal aid and other services	5000 (2011)	-	-	-	7000	Hivos Alliance (2014, p.69).

Back to result area 2

Result Area 3 (remaining indicators)	Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using					
Result Question 3a: To what extent has the use of sexual and reproductive healthcare services in the public and private sector improved?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Proportion of births attended by skilled health personnel of 20% richest	-	90%		(2007-2012): 85%	-	UN DATA (un.data.org), 2014: no new data available.
Percentage of HIV-positive pregnant women receiving treatment to prevent mother-to-child transmission of HIV - low- and middle income countries	(2005) 17% (2010) 48%	90%	62%	62%	73% globally / 77% (in 22 focus countries)	UNAIDS 2013, UNAIDS 2015 MDG6 report 2005: p.366, 2014: p.33 / p.368.
% of government's budget allocated to health sector - Sub-Saharan Africa / Health expenditure, public (% of government expenditure) Sub-Saharan Africa	(2004) 11%	15-20% of governmental expenditure(WHO)		(2008-2012): 11.5%	No recent data available*	WHO Health Financing 2014 *The WHO African Region Expenditure Atlas from November 2014 uses data from 2012.

Result Question 3b (1): With which results has your programme contributed to improved cooperation between public and private healthcare services? **Result Question 3b (2):** With which results has sexual and reproductive health care including emergency obstetric care become more affordable and accessible?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Partners have a staff policy in place that contributes to the sustainability, accessibility and quality of the health system at large	3	70%	13	41 (80%)	-	ICCO Alliance
% maternal health facilities with an increase in satisfaction by women	NA	40%	-	42,1%	-	SRHR Alliance

Back to result area 3 ◀

Result Area 4 (remaining indicators)	Greater respect for the sexual and reproductive rights of people to whom these rights are denied					
Result Question 4a: To what extent have the conditions for women, young people, sexual minorities, sex workers and intravenous drug users improved with regards to their sexual and reproductive rights?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**

Result Question 4b (1): With which results has your programme contributed to the identification of or changes in legal and policy barriers for the sexual and reproductive health of women, young (unmarried) people, sexual minorities, intravenous drug users and sex workers? **Result Question 4b (2):** With which results has your programme contributed to improving the access of these specific groups to sexual and reproductive health services and commodities?						
	Baseline	**Target 2017**	**Result 2012**	**Result 2013**	**Result 2014**	**Source**
Number of countries where health or health related policies changed to favor rights of vulnerable groups	2	4	3	4	-	ICCO Alliance
Increased involvement of community leaders in realisation of SRHR in % of the targeted communities	NA	50%	-	65%	-	SRHR Alliance
Community members and community leaders participating in SRHR awareness-raising activities at community level	NA	2.000.000	536.843	989.680	1.587.261	SRHR Alliance (2014, p.79)
Persons reached by SRHR awareness-raising activities through (new) media	NA	15.000.000	7.396.478	16.451.642	27.597.254	SRHR Alliance (2014, p. 79)

Back to result area 4

Extra Activities		2014	Implemented by		Rio marker		Gender marker
Number	Name	Actual expenditure	Name Organisation	channel	mitigation/adaptation	significant/principal	significant/principal
22188	DSO - Keuzes en kansen PSI	2.000.000	PSI (Population Services International)	NGO	Not applicable	Not applicable	Principal
23389	DSO Fonds keuze/kansen IHAA	2.000.000	International HIV/AIDS Alliance	NGO	Not applicable	Not applicable	...
26658	DSO - Kindhuwelijken SKN	1.626.189	Stichting Kinderpostzegels Nederland - SKN	NGO	Not applicable	Not applicable	Principal
26659	DSO - Kindhuwelijken SCN	1.507.386	Save the Children	NGO	Not applicable	Not applicable	Principal
21559	DSO NACCAP	1.380.213	NWO - Ned. Org. voor Wetenschappelijk Onderzk	Research institute and comp	Not applicable	Not applicable	Not applicable
23386	DSO PDP Hookwork vaccine SABIN	1.317.759	SABIN Vaccine Institute	NGO	Not applicable	Not applicable	Not applicable
26657	DSO - Kindhuwelijken SIMAVI	1.301.708	SIMAVI	NGO	Not applicable	Not applicable	Principal
26656	DSO - Kindhuwelijken Plan Ned	1.264.717	Plan Nederland	NGO	Not applicable	Not applicable	Principal
24590	Guttmacher SRHR Research 2013	1.210.680	The Alan Guttmacher Institute	Research institute and comp	Not applicable	Not applicable	Principal
25291	DSO - KP SRGR Fase III	1.025.000	Koninklijk Instituut voor de Tropen (KIT)	Research institute and comp	Not applicable	Not applicable	Principal
24173	DSO - NACCAP 2e fase	1.010.480	NWO - Ned. Org. voor Wetenschappelijk Onderzk	Research institute and comp	Not applicable	Not applicable	Not applicable
24368	DSO - AtMF 2012-2017	900.000	Stichting Access to Medicine Foundation (ATM)	NGO	Not applicable	Not applicable	Principal
23388	DSO PDP womens condom (PATH)	835.724	Program for Appropriate Technology in Health-PATH	NGO	Not applicable	Not applicable	Principal
24333	IPPF Civil Society & ICPD PoA	823.571	IPPF- International Planned Parenthood Foundation	NGO	Not applicable	Not applicable	Principal
25004	DSO SRGR BSR	794.200	BSR - Business for Social Responsibility	PPP or network	Not applicable	Not applicable	Principal
25003	DSO SRGR DSW	620.683	DSW - Deutsche Stiftung Weltbevoelkerung	NGO	Not applicable	Not applicable	Principal
24496	DSO - 'Roll-out' Medabon	478.474	The Concept Foundation	NGO	Not applicable	Not applicable	Principal
25006	DSO SRGR KIT	454.000	Koninklijk Instituut voor de Tropen (KIT)	Research institute and comp	Not applicable	Not applicable	Principal
25002	DSO SRGR HIVOS	432.000	HIVOS	NGO	Not applicable	Not applicable	Principal
25960	DSO Nodding Syndrome SSudan	310.000	Amsterdam Institute for Global Health & Dev'm	NGO	Not applicable	Not applicable	Not applicable
26225	DSO Fonds LS&H4D	268.337	RVO.NL (Rijksdienst voor Ondernemend Nederland)	Government	Not applicable	Not applicable	Principal

Go to result area 1

Extra Activities		**2014**	**Implemented by**		**Rio marker**		**Gender marker**
Number	Name	Actual expenditure	Name Organisation	channel	mitigation/adaptation	significant/principal	significant/principal
26458	DSO - XX Int. Aids Conf. 2014	154.000	International AIDS Society	NGO	Not applicable	Principal	Principal
23660	DSO ICSS 2012-2014	140.000	International civil Society Support	NGO	Not applicable	Not applicable	Principal
26164	DSO Kleine uitgaven GA 2014	138.172	Consultant Group	...	Not applicable	Not applicable	Principal
26621	Amplify Change	135.000	Manniondaniels Ltd	...	Not applicable	Not applicable	Principal
24811	Youth and ICPD Partnership	17.400	Dance4Life International	NGO	Not applicable	Not applicable	Principal
25039	DSO ICPD Beyond 2014 Review	6.840	UNFPA - United Nations Population Fund	Multilateral organization	Not applicable	Not applicable	Principal
6523	DSI NACCAP	0	NWO - Ned. Org. voor Wetenschappelijk Onderzk	Research institute and comp	Not applicable	Not applicable	Not applicable
17269	DSO Vrouwencondoom 2008-2010	0	Oxfam Novib	NGO	Not applicable	Not applicable	Significant
18817	DSI - Contributie IFFIm	0	IFFIm International Finance Facility for Immunisation	Multilateral organization	Not applicable	Not applicable	Not applicable
21848	DSO - GFATM	0	Global Fund to Fight AIDS, Tuberculosis and Malaria	Multilateral organization	Not applicable	Not applicable	Not applicable
22946	DSO - NWO/WOTRO GHSR platform	0	NWO - Ned. Org. voor Wetenschappelijk Onderzk	Research institute and comp	Not applicable	Not applicable	Not applicable
24581	Women Deliver 2013	0	Women Deliver	NGO	Not applicable	Not applicable	Significant
24601	DSO - High Level Taskforce	0	IPPF-International Planned Parenthood Foundation	NGO	Not applicable	Not applicable	Principal
24806	SAAF - Safe Abortion Action Fund	0	IPPF-International Planned Parenthood Foundation	NGO	Not applicable	Not applicable	Principal
25173	DSO - Vrouwencondoom FASE II	0	Oxfam Novib	NGO	Not applicable	Not applicable	Significant
26637	DSO - PMNCH 2014-2015	0	WHO (World Health Organization)	Multilateral organization	Not applicable	Not applicable	Principal
27181	DSO SRGR in post-2015	0	Action Canada for Sexual Health and Rights	PPP or network	Not applicable	Not applicable	Not applicable
27259	DSO - Kleine uitgaven GA	0	Consultant Group	...	Not applicable	Not applicable	Principal
				...	...	...	...
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Go to result area 1